



**STATE OF NEW HAMPSHIRE**  
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**DIVISION OF COMMUNITY BASED CARE SERVICES**

**BUREAU OF DEVELOPMENTAL SERVICES**

**Nicholas A. Toumpas**  
**Commissioner**

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**Commissioner**

129 PLEASANT STREET, CONCORD, NH 03301-3857  
603-271-4488 1-800-852-3345 Ext. 4488  
Fax: 603-271-4902 TDD Access: 1-800-735-2964

**Special Medical Services (SMS), the New Hampshire Title V Program for Children With Special Health Care Needs, offers health programs and services for children ages birth to 21 years, who have, or are at risk for, a chronic medical condition, disability or special health care need.**

**Attached is the application for Special Medical Services.** This application will need to be completed to apply for any of the following services provided by SMS:

▼ **Care Coordination**

- Provides community based care coordinators to assist families to access needed health care and related services for children with chronic illness or disability, including help with finding medical, social, psychological, educational and financial assistance and resources.

▼ **Neuromotor Clinic**

- Provides a specialized team approach and coordinated care for children with physical disabilities associated with significant orthopedic, neurologic, muscular and motor coordination delays.

▼ **Nutrition, Feeding and Swallowing Program**

- Provides a statewide network of pediatric nutritionists and feeding specialists offering in home consultation.

If you are interested in obtaining any of these services, please complete all sections of the application as completely as possible for the services requested.

If you are seeking diagnostic evaluation from a regional **Child Development Clinic**, do not complete this form; instead, please call the SMS toll free number for further information.

If you have additional questions or concerns about the application or our services, you may call our toll-free number 1-800-852-3345 ext. 4488 for further assistance.

All applications are reviewed to determine if your child or youth (the applicant) meets the eligibility requirements for the programs requested. SMS services are provided at no cost to families. Eligibility for assistance with non-covered medical care expenses will be determined if you have completed the financial assistance information section **and provided the required paperwork**. After the application has been received and reviewed an SMS Care Coordinator or Nutrition Program staff member will contact you to discuss how SMS can help you and your child.

**Return Completed Application to :**

DHHS/Special Medical Services, 129 Pleasant St., Thayer Bldg , Concord, NH 03301-3857



## SPECIAL MEDICAL SERVICES (SMS) ~APPLICATION FOR ALL SERVICES

SERVICES REQUESTED: ☐ CARE COORDINATION ☐ NUTRITION ☐ FEEDING & SWALLOWING ☐ NEUROMOTOR

APPLICATION IS FOR: ☐ CHILD (UNDER 18) ☐ SELF (OVER 18-21) FOSTER CHILD : YES/NO

APPLICANT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX: M/ F  
First MI Last

RESIDENCE: \_\_\_\_\_  
Street Address Town/City State Zip

Race / Ethnicity: ☐ White (Non-Hispanic) ☐ Black / African American ( Non-Hispanic) ☐ American Indian / Native Alaskan ☐ Asian  
☐ Native Hawaiian /Pacific Islands ☐ Multi-Racial ( Non-Hispanic) ☐ Hispanic ☐ Other (Non-Hispanic)

The State of New Hampshire, Department of Health and Human Services does not discriminate because of race, creed, color, sex, age, political affiliation or belief, religion, national origin, or handicap. There will be no unlawful discrimination in accepting or providing services.

<b>PARENTAL STATUS:</b> (Check one) <input type="checkbox"/> Married <input type="checkbox"/> Partners in Civil Union <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed					
Information below for ~Parent 1			Information below for ~Parent 2		
Name:			Name:		
Lives in the same Home as Applicant		Yes / No	Yes / No		
Residence Address ~ If NOT the same as Applicants					
Mailing Address ~ If NOT the same as Residence Address					
Who Should Receive SMS Information? (Circle)		Parent 1	Parent 2		
Work Place Name			Work Place Name		
List Below the Phone Numbers / E-Mail Contact (s) We Can Use To Reach You					
Parent 1 ~Home Phone	Cell Phone	Work Phone	Parent 2 ~ Home Phone	Cell Phone	Work Phone
E-mail ~			E-Mail ~		

### THIS SECTION FOR OFFICE USE ONLY:

<input type="checkbox"/> New Application <input type="checkbox"/> Yearly Update <input type="checkbox"/> Prior SMS Services (discharged over 1 year)					
SMS Case Number				Program Code	
Care Coordinator					

**Please List: All PARENTS AND CHILDREN THAT LIVE IN THIS HOUSEHOLD (HH)**

NAME	AGE	SEX M/F	US CITIZEN (Y / N)	RELATIONSHIP TO Child/ Adolescent seeking services	LAST GRADE COMPLETED (1 – 12 +)	SPEAKS ENGLISH (Y / N)	RECEIVES SSI (Y / N)	OTHER HH MEMBERS ENROLLED IN SMS (Y/N)
1				Applicant				
2								
3								
4								
5								
6								

This area is about ~ **Child / Adolescent who is applying for services**

Who referred you? \_\_\_\_\_ Medical /Primary Diagnosis of Applicant \_\_\_\_\_

**HEALTH INSURANCE:** Is the Applicant covered by Health Insurance? ☐ Yes ☐ No ☐ Not Sure

**Private Health Insurance:** \_\_\_\_\_ Name of policy holder: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Is this a managed care /HMO plan (i.e., requires a primary care physician's referral for services)? **Y / N**

Insurance Number: \_\_\_\_\_

Deductible \$ \_\_\_\_\_ Co-pays Rx Drugs \_\_\_\_\_ Co-pays Office Visits \_\_\_\_\_ DME Limit \_\_\_\_\_

**Medicaid:** ☐ Yes ☐ Never Applied ☐ Pending Application

Medicaid ID Number: \_\_\_\_\_ District Office \_\_\_\_\_

**Healthy Kids Silver:** ☐ Yes ☐ No ID Number ; \_\_\_\_\_

**Private Dental Insurance:** Dental Insurance? ☐ Yes ☐ No Name of company: \_\_\_\_\_

Deductible \$ \_\_\_\_\_ Co-pays Office Visits \_\_\_\_\_ % of coverage routine \_\_\_\_\_ Limit \_\_\_\_\_

**Only complete this section if applying for SMS Financial Help; If You are not applying for Financial Assistance Please sign /initial here: \_\_\_\_\_**

### FINANCIAL ASSISTANCE INFORMATION

Special Medical Services offers financial assistance. Financial assistance is based on income criteria, and is given after insurance and other resources have been exhausted. **Bills are paid at Medicaid Rates. You must attach copies of appropriate paperwork to support your income as reported below**

Name Of HH Member/Partner	Applicant		Parent/Guardian 1		Parent /Guardian 2	
Name of whose income you are reporting:						
<b>Gross Earned Income</b>						
Monthly Wages; Total amount of the last 2 months of pay stubs <b>OR</b>						
Amount from Last years 1040 Tax Form; before deductions <b>OR</b>						
Amount from Last years 1040 Tax Form; Schedule C						
<b>Unearned Income (Monthly Total)</b>						
Social Security/Disability (SSI/SSA)						
Child Support/Alimony Received						
Unemployment Compensation						
Cash Assistance (i.e. TANF /FAP/APTD/ANB)						
Pension/VA Benefits						
Insurance benefits from accident or injury						
Dividends (trust/annuities /settlement)						
<b>Accessible Resources (Excluding Special Needs Trust)</b>						
Trust Funds / IRA Accounts (cash value without penalty)						
Checking Accounts						
Savings Accounts						
Stocks / Savings Bonds / CD's						
<b>Expenses</b>	Mo	Yr	Mo	Yr	Mo	Yr
Health Insurance: Paid through Employer or Family (premium Mo/Yr)						
Dental Insurance: Paid through Employer or Family (premium Mo/ Yr)						
Court Ordered Child Support (Paid to someone outside the HH)						
Specialty Diet Foods for Medical Condition (Monthly Expense)						
Household Child Care Expenses (Monthly Cost)						

*Request for Financial Assistance Continued*

By my initials, I declare that these financial statements are correct and true to the best of my knowledge. I realize that any intentional misrepresentation may result in legal action against me since Special Medical Services receives its funds from State and Federal sources. \_\_\_\_\_ (Initials)

**HEALTH CARE EXPENSES**

Expenses can be used as a deduction in the determination of financial assistance for this application.

**ANY PAID or OWED health care expenses incurred by any member of the family that resides in the same household as the applicant that have a date of service no more than 1 year from the date of application.**

Do not include bills that have been or will be paid by your employer, health insurance, Medicaid or any other source/agency.

Service was for (Name)	Date of Service	Type of Service Dental~ Hospital ~ Medications ~ Office Visit~ Medical Supplies	Total of Billed Amount	Amount Paid by You	Date Paid	Remaining Balance Owed By You

If you need more room add above information on a blank page.

**As a reminder any bills that are used above as a deduction to become eligible for financial assistance will not be paid by SMS and will remain your responsibility to make arrangements for payment. These bills may also only be used and submitted one time.**

**THOSE THAT CURRENTLY TREAT AND SERVE YOUR CHILD OR ADOLESCENT**

(Please fill out as much information you have available about the provider)

<b>Types of Providers</b>	<b>Name</b>	<b>Address</b>	<b>Telephone</b>
Primary Care Provider			
Specialist (type of)			
Other Physician / Specialist			
Other Physician / Specialist			
Dentist			
<b>School /Early Intervention</b>			
Name of School or EI Program			
Teacher			
Special Educator			
Speech Therapist			
Physical Therapist			
School Nurse			
Case Manager			
Other			
<b>Community Based Services</b>			
Area Agency			
Partners in Health			
Home Nursing Services			
Nutrition, Feeding and Swallowing Provider			
Equipment Vendors			
Other			

## HOW CAN SMS HELP YOU AND YOUR FAMILY

Please check the boxes next to any of the areas that you would like to discuss with your care coordinator, obtain more information about or that you may need assistance with

### INFORMATION ABOUT

- ☐ Our Child's Health Condition/ Diagnosis
- ☐ Nutrition/Feeding
- ☐ Child's Behavior
- ☐ Child's Development

### KNOW MORE ABOUT GETTING MEDICAL AND DENTAL CARE

- ☐ Finding Specialty Care Services
- ☐ Getting Therapy
- ☐ Finding A Doctor
- ☐ Finding A Dentist
- ☐ Making Physical Changes In Our Home
- ☐ Getting And Using Special Equipment
- ☐ Getting Help To Pay For Medical Care Or Medications

### TO KNOW ABOUT COMMUNITY SERVICES

- ☐ Managing The Daily Needs Of My Child At Home
- ☐ Financial Assistance
- ☐ Sibling Support
- ☐ Special Education Process
- ☐ Social/Recreation Opportunities
- ☐ Transportation
- ☐ Medical Insurance

*You have now completed the SMS application; please sign below;*

Person who filled out the application \_\_\_\_\_ By signing my name I attest to all information to be true and correct to the best of my knowledge.

Relationship to Applicant \_\_\_\_\_ Date Completed \_\_\_\_\_

**Mail Application to: DHHS / Special Medical Services**

**129 Pleasant St ~ Thayer Bldg, Concord NH 03301**

### HELP WITH CARING FOR OUR CHILD

- ☐ Respite Care
- ☐ Finding Daily Child Care
- ☐ Finding Babysitters/Respite Care
- ☐ Finding Ways To Pay For Child Care/ Respite
- ☐ Evaluating Child-Care Settings
- ☐ Teaching Care Providers How To Take Care Of Our Child

### HELP TALKING ABOUT OUR CHILD

- ☐ To Our Children, Friends, Or Family
- ☐ To Professionals To Get Information We Need And Want
- ☐ Emotional Support For Self Or Child To Help Cope With Condition
- ☐ With Other Parents In A Similar Situations
- ☐ Teachers/School Personnel
- ☐ Individual / Family Counseling

### HELP PLANNING FOR THE FUTURE

- ☐ Future Health Care Needs
- ☐ Determining Residential Needs
- ☐ Transitioning To Adult Services
- ☐ Preparing A Teen To Manage Their Own Health Care

Only Complete This Section If Applying For Nutrition, Feeding & Swallowing Services

## GUIDELINES FOR NUTRITION FEEDING AND SWALLOWING

(Please Circle)

<b>Yes</b>	<b>No</b>	Does your child have any food allergies?				
<b>Yes</b>	<b>No</b>	Does your child take any medication on a regular basis?				
List all medications (including vitamins, minerals and herbal supplements)						
<b>Yes</b>	<b>No</b>	Does your child use a feeding tube or any other specialized feeding equipment?				
(Please list)						
<b>Yes</b>	<b>No</b>	Does your child take a bottle to bed?				
<b>Yes</b>	<b>No</b>	Do you add solid foods to your child's bottle?				
<b>Yes</b>	<b>No</b>	Is your child is under 12 months old and drinks less than 24 ounces per day of formula?				
<b>Yes</b>	<b>No</b>	Is your child over 12 months old?				
If yes:				<b>Milk</b>		
Does your child reject the following foods? (Check all that apply)				<b>Meats</b>		
<b>Yes</b>	<b>No</b>	Is your child's behavior upsetting during meals? Ex. Throws food/silverware/utensils refuses to eat.				
If yes explain:						
<b>Yes</b>	<b>No</b>	Do you find that you are out of food at the end of the month?				
<b>Yes</b>	<b>No</b>	Do you have concerns about your child's nutrition & feeding?				
If yes explain:						
<b>Yes</b>	<b>No</b>	Do you have WIC (woman, infants & child food program)?				
<b>Yes</b>	<b>No</b>	Is your child enrolled in a well –child clinic?				
Does your child experience any of the following?				Diarrhea		
Does your child have any difficulty with?				Constipation		
				Vomiting/ reflux		
				Sucking		
				Swallowing		
				Chewing		
				Gagging		
At your child's current age which of the following currently apply (check all that apply)?						
		7 month or older; has not started using a cup		12 months or older; drinks primarily from a bottle (liquids)		
		9 months or older; does not finger feed		19 months or older; does not use a spoon.		

**Your signature allows Nutrition, Feeding and Swallowing to bill your Insurance Company for services rendered.**

**Insurance Name:** \_\_\_\_\_

**Insurance ID** \_\_\_\_\_

**Subscriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. **I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.**

**This Authorization will allow the release of Protected Health Information for:**

**Childs Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Specific description of information that may be used/disclosed:	Persons/organizations authorized to use and/or disclose the information:
Type of Protected Health Information (PHI) requested	Name and Address of Office to obtain requested information
Birth Records (Child >12 months old)	
Growth Charts	
Nutritionally relevant laboratory reports	
Medical progress and Office notes (Primary Care Physician)	
Medical progress and Office notes (Specialist)	
Medical progress and Office notes (Specialist)	
Medical progress and Office notes (Speech, Physical or Occupational Therapist.)	
School / Current IFSP /IEP records:	
Other Specified Person or Agency to release PHI from	

As Parent or Legal Guardian of the above listed child, I hereby give permission to ***Special Medical Services and our Contractors*** (Child Health Services and The Nutrition, Feeding and Swallowing Program) as the **Persons/organizations authorized to receive the information. The information will be used/disclosed for the following purposes:** to facilitate coordination of services and for treatment in clinics.

I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that the Department will not condition treatment, payment or enrollment in a health plan based on this authorization. I understand that I may revoke this authorization at any time by notifying the Department in writing. However, the revocation will not be valid if:

- a. The Department has taken action in reliance on this authorization; or
- b. If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

A copy of this authorization will be as valid for the period of one (1) year from the date application was signed concurrent with dates listed below. This consent may be withdrawn at any time upon my written request to Special Medical Services.

**Authorized Record Dates: From** \_\_\_\_\_ **To:** \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent / Legal Guardian (attach documentation)

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship

*The HIPAA Privacy Rule defines a health oversight agency to include a Federal or other governmental agency or authority that is authorized by law to oversee the health care system (whether public or private), or government programs in which health information is necessary to determine eligibility or compliance with program standards (45 CFR 164.501). Oversight agencies also include a person or entity acting under a contract with the public agency. Under 42 CFR 164.512(d), a covered entity may disclose protected health information to a health oversight agency without the patient's permission for oversight activities authorized by law, including oversight of compliance with program standard*